AMCHP Annual Conference, 2010

Moving Ahead Together:

Celebrating the Legacy, Shaping the Future of Maternal and Child Health

From Analysis to Action:

Addressing Maternal Morbidity and Mortality at the State and International Levels

March 6-10, 2010

SHABIR AHMAD: Good afternoon, my name is Shabir Ahmad and I am the Title V Director for California MCH Program at the Department for Public Health in Sacramento. This session is G9 Session and the title of the session is “From Analysis to Action: Addressing Maternal Morbidity and Mortality at the State and International Levels”. We have four speakers and this session is also eligible for continuing education that would be a web page on (inaudible) after the conference and you can go in the (inaudible) website to claim for your continuing education units. I will request if you can turn your cell phones to a silent mode that would be helpful. There are four speakers as I said and they will each take 15 minutes and after each talk there may be one or two burning questions but if your question is not that burning I would keep it at the end for the QA session, which will be 10 to 15 minutes. There are three handouts. One I put it on the chair and there are two on the back and lastly there is an evaluation sheet at the end of the session. You will be provided with that and please fill this sheet because that is important information and feedback from you to improve the conference for future years.

So, we have four speakers Betsy McCallon, who is the Deputy Director, White Ribbon Alliance for Safe Motherhood. The second speaker is Jason Disterhoft. He is the Economic, Social and Cultural Rights Campaigner at Amnesty International USA and the third speaker is Dr. Karen Ramstrom who is the Branch Chief for Policy Development at the California Maternal and Child Health Program. The last speaker, Dr. Connie Mitchell who is the lead on the maternal health at the California Maternal and Child Health Program.

The session, actually there were two abstracts submitted from California and the other one from Betsy and Jason and we spoke about the contents of the representations and you will hear both at the international and national level and at the state level what is being done for maternal morbidity and maternal mortality. Each speaker will introduce himself or herself for just adding a brief bio so that you know what their activities in the perspective organizations are. So, I will first invite Betsy McCallon. Please join me in welcoming Betsy to the podium for the first talk.

(Applause)

BETSY MCCALLON: Thank you, Shabir. I'm Betsy McCallon and I am the Deputy Director of the White Ribbon Alliance, which is an international coalition of organizations and individuals that are working to improve maternal and newborn health around the world. So in some ways I'm a bit of a guest here at this conference. I'm really excited to be here and share a bit of the work that we do internationally but how it all links in to the

work and the similarities of things that are going on here in the states but also to just share a bit and hope that some of you may be interested in also exploring ways to get involved globally. What I'm going to do is provide a very brief overview of the issues of maternal mortality globally, talk a little bit about the White Ribbon Alliance specifically and how we work at those various levels, globally, nationally and at the grassroots level.

So, these are the statistics for you. They haven't changed for a longtime. It's just that every minute, somewhere in the world, a woman dies of pregnancy related causes. I wanted to highlight that with that rather sobering statistics one of the things that is really key around maternal mortality is about disparities. The lifetime risk of a woman giving birth in a country like Niger is one in seven of dying in pregnancy in childbirth, similarly in Afghanistan compared to women in Sweden who have a one in 17,400 chance of dying or women in the US who have a one in 4,800 chance of dying in pregnancy and childbirth. But, just as importantly as looking within countries such as Peru where the poorest quintile of women are six times more likely to die in pregnancy and childbirth then the richest quintile of women. So, we have disparities across rich and poor countries. 99% of these maternal deaths are happening in developing countries but we also have massive disparities within countries. As many of you know, the situation in the states is not anything to brag about either. The maternal mortality rates have not improved in 20 years and in fact in 2004 statistics we saw a bit of an increase in overall mortality rates in the United States. In fact, the US globally ranks 41st in terms of lifetime risk of dying in pregnancy and childbirth.

The medical causes of maternal mortality are well known and they look pretty much the same the world over. Hemorrhage or severe bleeding is the number one direct cause and killer of women followed by septic cysts or infections. We still have a startlingly high rate of deaths related to complications from unsafe abortion. Eclampsia and obstructed labor account for the other deaths but what we also know is it's not just the medical causes and that there are a lot of other underlying issues to women's overall access to healthcare as well as education, her socioeconomic status and very importantly her decision making ability, whether she has decision making ability within her household or community to make decisions about her own body and her own health and health seeking behavior.

Again, I think one of the big disparities relates to skilled health workers and this slide is a little bit hard to read I'm afraid I think but it just highlights again that in Ethiopia for example only 6% of women deliver with trained health personnel, midwives, doctors and other healthcare providers with midwifery skills. In Bangladesh the statistics overall are a little bit better but when you break it down again by wealth quintiles you find that in the poorest women only 3% are delivering with a skilled healthcare provider compared to 40% for wealthy women in Bangladesh. So, the majority of poor women in Bangladesh are giving birth either alone or with an untrained traditional birth attendant, neighbor or friend. Similarly in Latin America we see in particular these very high rates overall of deliveries with trained health personnel but again over a quarter of the poorest women will deliver without any skilled help but we know what needs to happen to address this issue and we've known for a longtime. To prevent maternal mortality and morbidity we

talk about four key pillars. Women's access to reproductive health services and in particular family planning, women's access to education. Her access to skilled birth attendants. Again, delivering with skilled personnel in an environment that is equipped properly and then lastly access to emergency obstetric care in case of complications and post-partum care.

So, as I mentioned, I'm with the White Ribbon Alliance and what we are is a grassroots movement really that is trying to unite organizations and individuals from all walks of life who believe that women in this day and age shouldn't be dying needlessly in pregnancy and childbirth. The White Ribbon Alliance was formed in 1999, very loosely then as a coalition and has grown now to have members in a 148 countries around the world and part of the reason for the alliance forming was the recognition that if we were going to change these statistics that have been the same for so long and have been the status quo for so long, we needed to involve some new players. This issue couldn't be and shouldn't be left to healthcare personnel alone but needs to be something that's addressed by everyone at all levels. Everyone has a part to play in reducing maternal mortality whether you're a policymaker, a programmer, someone from the media, from the business sector, students and ordinary citizens and part of our role is really amplifying the voices particularly from countries with a high burden of mortality on to the global stage. We have as our symbol the white ribbon, which there is some in the back for those of you who would like one. White was chosen because in some countries white represents hope and in some countries white represents mourning. So, we

selected white to mourn the death of women who have needlessly lost their lives but we have hope that as a united group we can work to change these statistics.

Today is International Women's Day. Some of you may know. It's actually the 100th year of International Women's Day and we've been working with our alliance members around the world. There are activities happening today in over 30 countries that are engaging the media to tell these stories to tell that it is still happening and who it is happening to and why and what needs to change. We're also holding rallies and marches and dinner parties and seminars and all sorts of different events to rally members together around the world and lastly, which is why I'm wearing a slightly seasonally inappropriate, white today to again honor those women who we've lost and to show our hope and solidarity to change that in the future.

Specifically, much of our work takes place in 15 countries where we have affiliated national alliances meaning that organizations and individuals who are about these issues have come together to come up with a common platform of action. What is it that they think needs to change most in their countries and that they can do together? The way we work as I mentioned is really at three different levels; at the grassroots level in communities around the world, at the national level advocating for change from policymakers and then, globally through a maternal/mortality campaign uniting all of the work of our members around the world around key changes and also working around key moments when world leaders gather together to make decisions about where the world's funding goes and what is a priority.

None of it works though if there isn't interception between the pieces and what happens at the grassroots and national level in particular really feeds not only the priorities for the global level but also the stories and the quite specific policy ads. So, I just want to give a couple of very quick examples of the kind of work that happens with our members who have come together as I said in their communities very much locally to address problems affecting women and one of our member organizations in Nigeria for example decided that one of the biggest barriers and one of the reasons that mortality remains very high was because access to healthcare was really expensive. So, they banded together with an advocacy campaign to make antenatal or prenatal and postnatal services free and they were successful at that initially in their district and then through the entire state of Enugu in Nigeria for free healthcare services for women. So, it's those kinds of very localized collective actions that our members are doing around the world that feed into our then national level campaigns. Some examples of what happens at the national level. In Tanzania, the alliance members there recognized that one of the biggest barriers facing women was lack of healthcare providers as a whole. So, again they launched an advocacy campaign to lobby the government to increase the number of healthcare workers trained, deployed and retained particularly in rural areas. You'll see there, President Kikwete of Tanzania coming onboard and launching that campaign and he's now really recognized as a global leader on issues of maternal and newborn health. Another example of that kind of advocacy at the national level is in India where again with a gap in healthcare providers and particularly providers that are able to perform particular lifesaving skills the alliance in India lobbied the national government

to allow auxiliary nurse midwives to perform specific lifesaving skills like starting an IV for example.

We also have a campaign nationally here in the US that I just wanted to share with all of you in case any of you are interested in getting involved. We launched it last year with CARE and it's really about advocating for greater US leadership both investment but also leadership towards Millennium Development Goal V, which is to reduce maternal mortality by 75% around the world. We formed a bipartisan advisory committee to keep this issue on the political forefront here in the US. As I said then globally everything we do at the grassroots and national level feeds into the international. Sarah Brown, you'll see pictured in a number of these photographs is the wife of the UK prime minister and she's come onboard with us as a patron and has really been a huge advocate for maternal and newborn health globally and has helped to elevate these issues to a new stage.

Something else that happened that was quite exciting last year, for the first time ever when the G8 met they addressed this issue and they signed on to what is called, "The Consensus for Maternal, Newborn and Child Health", which is basically five key things that have to be in place in order to save the lives of women and children including political leadership, effective health systems, removing barriers for women to access care, skilled health workers as I've mentioned several times and accountability for results. But, that's nice. That's in the G8 manifesto but what was really key is what happens this year in 2010 to really deliver on that kind of commitment and so we've

outlined four key themes that we're working on internationally, nationally and the grassroots level, which include pushing for more resources for maternal and newborn health at every level. We're also pushing that it be recognized that maternal mortality is a key indicator of how well a health system is functioning overall and I think the rankings that we show will tell us quite a bit about the health systems in various countries. What needs to be in place to address maternal mortality is then in place to address a whole host of other health issues. Again, pushing for training, recruiting and retaining more health workers to fill the gap and then removing barriers to quality healthcare whether that be financial barriers, social and cultural barriers or logistical barriers like transportation, which is a huge issue in so many countries. As I said there are key moments in 2010 where we really hope to push for quite concrete action and delivery on financial commitments but also an action plan to accelerate progress that includes the G8 Summit, the African Union Summit and then in September the United Nations will be doing a review of progress towards the Millennium Development Goals.

So that was very brief. I just want to encourage any of you who are interested to checkout our website. You can join to become members of the White Ribbon Alliance and I have some newsletters and some white ribbons, as I said in the back of the room.